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Critical Race Feminist Bioethics: Telling Stories in Law School and Medical School in Pursuit of "Cultural Competency"

Deleso Alford Washington
Florida A&M University College of Law, deleso.alford@famu.edu

CRITICAL RACE FEMINIST BIOETHICS: TELLING STORIES IN LAW SCHOOL AND MEDICAL SCHOOL IN PURSUIT OF "CULTURAL COMPETENCY"

*Deleso Alford Washington**

A SISTERSONG BALLAD[1]

I know Sisters.

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* Associate Professor of Law, Florida A&M University College of Law; J.D., Southern University Law Center; LL.M, Georgetown University Law Center. Earlier versions of various sections of this article benefited immensely from the comments of participants during panel presentations including: American University Founders' Celebration, Feminism and Legal Theory Project; Second National People of Color Legal Scholarship Conference; Southeast/Southwest Scholars of Color Conference (New Orleans, LA and Santa Fe, NM); Storytelling and the Law: A Retrospective on Narrative, Ethics and Legal Change, sponsored by the Feminism and Legal Theory Project, Emory University School of Law, Atlanta, GA; Once Upon a Legal Time: Developing the Skills of Storytelling in Law, Applied Legal Storytelling Conference sponsored by City University and the Legal Writing Institute, The City University's Inns of Court Law School, London, UK; American University Founders' Celebration 2008, American University Washington College of Law; "The Teaching For Social Change" Conference co-sponsored by the Society of American Law Teachers (SALT) & University of California, Berkeley, School of Law Boalt's Thelton E. Henderson Center for Social Justice; "New Approaches to Critical Legal Pedagogy" session at the Joint Meetings of the Law and Society Association and the Canadian Law and Society Association (ACDS), Montreal, Canada; Northeastern People of Color Conference (NEPOC), Boston University School of Law, Boston, MA; Commemorating 1808: Fighting for the Right to Dream, The University of Toledo College of Law, Toledo, Ohio; "CRT 20: HONORING OUR PAST, CHARTING OUR FUTURE," University of Iowa College of Law, Iowa City, IA; and Gender, Race, and Class Perspectives: The "Practice of Medicine" session at the 2009 Annual Meeting of the Law and Society Association, Denver, Colorado.

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[1] An original, previously unpublished poem written by Author and dedicated to the Sister Song Women of Color Reproductive Health Collective.

I know Sisters who lived lives full enough to be stories-
"Her-stories" untold,
Carried through the heartbeat of mother's wit . . . all the time being "othered" by legal fictions that turn humans to chattel property;
Allowing her and "her-story" to be created, bought and sold.
I know Sisters.
Sister Anarcha got a story for all to take heed.
Her-story cuts so deep, make you bear down, close your eyes and legs . . .
Once you hear how her private was made public,
With fine silver wires sewn together without anesthesia,
Just like she was broke and needed fixin' in order to breed.
I know Sisters.
Sister Betsey got a story make your head spin around twice.
Her-story led to the development of the urinary catheter,
Yet another invention—pulled on and sewn up
Perfected on her "othered" existence,
Amounting to a historically accepted, but marginalized vice.
I know Sisters.
Sister Lucy got a story that laid the foundation for the medical specialty of gynecology,
Her-story gave meaning to a pewter spoon,
Both ends bent and inserted to open "the way"
To see fistulas evidencing the truth
About 'property' bearing human crop,
Resulting in a prototype for both you and me.
I know Sisters.
I know Sisters who know Sisters who lived lives full and deep enough to be stories-
"Her- stories"
Seeing the light of day, heard through lyrics in her song
All the time being centered by her-storical accuracies;
Allowing Sisters to tell "her-story"
In her rhythm and blues, soulful gospel,
Jazzed up by the hip-hop, caught up in the *rap*-ture . . .
As only a Sister can, in her own words, in her own way.
I know Sisters.
I know Sisters who write their own sister song ballads,
As reproductive wrongs twist and shout,
To revere the lives lived of Sisters past, and lives to be lived of Sisters present

And for the life of every Sister yet to come;
Whose lives together compose the "Her-stories"
Worthy to be song about.

INTRODUCTION

This article examines how slavery[2] and the concept of race[3] intersect with gender[4] to construct a distinct notion of science and technology that has been historically marginalized at best. The particular aspect of "science" that I explore is the development of the medical specialty of gynecology[5] in the United States. I specifically look at "technology," historically referred to as Sims's[6] instruments, Sims's gynecological innovations[7], and Sims's inventions,[8] circa 1845–1849, which are still used today. I argue

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[2] *See generally* KENNETH M. STAMPP, THE PECULIAR INSTITUTION: SLAVERY IN THE ANTE-BELLUM SOUTH (Knopf, Inc. 1956).

[3] Jayne Chong-Soon Lee, *Navigating the Topology of Race*, 46 STAN. L. REV. 747, 751 (1994) (noting that "[h]istorically, the terrain of race has shifted between definitions of (1) race as biological characteristics, historical commonality, or essential identity, and (2) race as the erroneous categorization of people, or the false attribution of traits to people. Both definitions, however, locate race as an attribute within people rather than as a complex set of relations between people"); STEPHANIE Y. MITCHEM, AFRICAN AMERICAN FOLK HEALING 44 (2007) (noting that "[i]n the nineteenth century, African American Anna Julia Cooper advanced one of the first arguments to understand the social construction of race, class, and gender: 'Race, color, sex, condition are realized to be the accidents, not the substance of life, and consequently as not obscuring or modifying the inalienable title to life, liberty, and pursuit of happiness'"); *see* Lisa C. Ikemoto, *Race to Health: Racialized Discourses in a Transhuman World*, 9 DEPAUL J. HEALTH CARE L. 1101, 1101 (2005); *see also* Anthony Paul Farley, *The Black Body As a Fetish Object*, 76 OR. L. REV. 457, 464 (1997).
Farley notes:

> Race is a form of pleasure in one's body which is achieved through humiliation of the Other and, then, as the last step, through a denial of the entire process. We deny it through a discourse in which "race" appears as a thing created by nature and not as a practice developed by a culture. By denying their fetishization of "race," whites create a culture in which they are both masters and innocents.

[4] *See generally* Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139 (1989); Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1279 (1991); CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT 354 (Kimberlé Crenshaw et al. eds., 1995).

[5] Gynecology is defined as, "[t]he medical specialty concerned with diseases of the female genital tract, as well as endocrinology and reproductive physiology of the female." STEDMAN'S CONCISE MEDICAL DICTIONARY FOR THE HEALTH PROFESSIONS 419 (John H. Dirck ed., 4th ed. 2001).

[6] J. MARION SIMS, THE STORY OF MY LIFE 26–27 (DaCapo Press 1968) (1884).

[7] *Id.* at 433, 452–54, 468; *see also* A SYSTEM OF GYNECOLOGY BY AMERICAN AUTHORS 394–96, 400 (Matthew D. Mann ed., 1888) [hereinafter SYSTEM OF GYNECOLOGY] (illustration of wood engraving depicting "Sims' Operation of Fistula" and Removal of Silver Sutures).

[8] SIMS, *supra* note 7, at 27; SYSTEM OF GYNECOLOGY, *supra* note 8, at 396, 399; 578, 845

that the particularized and unique experiences of enslaved Black women have been traditionally viewed as extracting assets from her body in the form of a "crop of human labor"[9] in the historically referred to role as a so-called "breeder."[10] The focal point of this article is to explore a means to address the impact of continuing to tell the narrative on the development of the medical specialty of gynecology in the United States without the benefit of a "her-storical" lens. The reproductive and surgical exploitation meted upon three enslaved women, Anarcha, Betsey, and Lucy, among other un-named enslaved Black women, "othered"[11] their skin based upon a construction of "race," yet "samed" their bodies for purposes of extracting reproductive knowledge, surgical inventions, and innovations to benefit all women.[12] The story of Anarcha, Betsey,

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(illustration of wood engravings depicting "Sims' Needle-Holder with Needle"; "Sims' Shield or Fulcrum"; "Sims' Sigmoid Catheter"; "Sims' Self-Retaining catheter"; "Sims' Dilator"; and "Sims' Depressor").

[9] *See* Pamela D. Bridgewater, *Un/Re/Dis Covering Slave Breeding in Thirteenth Amendment Jurisprudence*, 7 WASH. & LEE RACE & ETHNIC ANC. L.J. 11, 14 (2001) [hereinafter Bridgewater, *Un/Re/Dis Covering*]; Barbara L. Bernier, *Class, Race, and Poverty: Medical Technologies and Socio-Politcal Choices*, 11 HARV. BLACKLETTER L.J. 115, 128 (1994); *see also* Pamela D. Bridgewater, *Reconstructing Rationality: Towards A Critical Economic Theory of Reproduction*, 56 EMORY L.J. 1215, 1222 (2007).
Bridgewater points out:

> The end of the international slave trade in 1808 gave rise to the macroeconomic implications of these laws. The slave economy—indeed the institution itself—would have to depend almost exclusively on the "natural" increase of slaves. Reproduction and the laws that regulated it proved essential to keeping the economy supplied with slaves. Several plantation owners took full advantage of the profitability of the rape and impregnation of slaves.

[10] Pamela D. Bridgewater, *Ain't I A Slave: Slavery, Reproductive Abuse, and Reparations*, 14 UCLA WOMEN'S L.J. 89, 120–21 (2005) [hereinafter Bridgewater, *Ain't I A Slave*].
Bridgewater states that:

> [t]he historians who describe slave breeding suggest that it was akin to animal husbandry. It consisted of a concerted effort to increase the number of slave holdings by forcing female slaves to reproduce. Several methods were used to facilitate increased reproduction rates. Some slave owners identified slaves for breeding and paired them. Others sold good breeders to the market. Still others were personally involved in the breeding process via rape of their slaves.

Id.; see also Bernier, *supra* note 10, at 128; JENNIFER L. MORGAN, LABORING WOMEN: REPRODUCTION AND GENDER IN NEW WORLD SLAVERY 40 (2004).

[11] Deleso Alford Washington, *"Every Shut Eye, Ain't Sleep": Exploring the Impact of Crack Cocaine Sentencing and the Illusion of Reproductive Rights for Black Women from a Critical Race Feminist Perspective*, 13 AM. U. J. GENDER SOC. POL'Y & L. 123, 132 (2005) (citing MARIMBA ANI, YURUGA: AN AFRICAN-CENTERED CRITIQUE OF EUROPEAN CULTURAL THOUGHT AND BEHAVIOR 402–04 (1994) (defining the "cultural other" as a creation of imperialistic European culture whereby peoples with non-European cultural histories and traditions are categorized as nonhuman, and therefore, undefined).

[12] MARIE JENKINS SCHWARTZ, BIRTHING A SLAVE: MOTHERHOOD AND MEDICINE IN THE ANTEBELLUM SOUTH 228 (2006). Schwartz sums it up this way:

> Although all women ultimately would benefit from surgical advances, the goal for slaves was more immediate: to correct any aberrations that impeded a woman in performing

and Lucy is the marginalized story of how the laws of enslavement sanctioned medical experimentation and exploitation upon the bodies of Black women. I posit that the telling of Anarcha, Betsey, and Lucy's narrative[13] in medical schools will aid current efforts to attain cultural competency.[14]

The bioethics[15] principle of truth-telling[16] is traditionally viewed from the doctor-patient relationship, however, existing racial and ethnic reproductive health care disparities mandate culturally competent training from a critical race feminist[17] perspective that suggest *historical* truth-telling in medical schools to students through the use of narrative[18] as a modality. I propose in this article, what I refer to as Critical Race Feminist (CRF) Bioethics as a tool which focuses on the realities of women of color with aspects of an approach that pays attention to the point of view of women of color bodies [19] and experiences with interfacing with the healthcare system of the past and present.

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reproductive and productive labor. The most ambitious and innovative of surgeons hoped to pioneer cures for "diseases of women" that would earn fame and fortune as well as eliminate suffering among all classes by exploring new treatments with captive patients. *Id.*

[13] The narrative of Anarcha, Betsey and Lucy has been acknowledged. *See* Bernier, *supra* note 10, at 118; Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 197 (1996); *see also* Washington, *supra* note 12, at 129–33. *See generally* Camille A. Nelson, *American Husbandry: Legal Norms Impacting The Production of (Re)Productivity*, 19 YALE J.L. & FEMINISM 1 (2007).

[14] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH RESOURCES AND SERVICES ADMINISTRATION, BHPR—OTHER DEFINITIONS OF CULTURAL COMPETENCE (2009), http://bhpr.hrsa.gov/diversity/cultcomp.htm.

> Cultural competence comprises behaviors, attitudes, and policies that can come together on a continuum that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups. Cultural competency is a goal that a system, agency, program or individual continually aspires to achieve.

Id.

[15] Bioethics is defined as "[t]he branch of applied ethics that studies the value implications of practices and developments in the life sciences, medicine, health care and the environment." KENNEDY INSTITUTE OF ETHICS, BIOETHICS THESAURUS (1999).

[16] Philip C. Hébert et al., *Bioethics for Clinician: 7. Truth Telling*, 156 CAN. MED. ASS'N J. 225, 225–26 (1997).

[17] *See generally* ADRIEN K. WING, INTRODUCTION TO CRITICAL RACE FEMINISM: A READER 1 (2d ed. 2003).

[18] According to Richard Delgado, "[t]elling stories invests text with feeling, gives voice to those who were taught to hide their emotions. Hearing stories invites hearers to participate, challenging their assumptions, jarring their complacency, lifting their spirits, lowering their defenses." Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2440 (1989).

[19] *See generally* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY (1997) (describing the interaction of reproductive issues and race).

This article argues that CRF Bioethics enhances the ability of medical practitioners to humanize present interactions with diverse populations based on knowledge of a historically marginalized past narrative involving medical technology, specifically the specialty of gynecology and the advancement of this specialty through the laws of enslavement.

Part I explores the use of storytelling and narrative analysis in legal and medical educational settings as a viable approach to enhance learning as well as benefit ultimate professional interactions. This part focuses on the individual experiences of Anarcha, Betsey, and Lucy, oftentimes over-looked in medical history, who were forced by the laws of enslavement to lay at the intersection of gender, race, and class in pursuit of science and technological advancement.

Part II examines the historical development of the field of Bioethics and offers a new approach to address the specific needs of women of color and reproductive health.

Part III focuses on the current needs of medical education to attain cultural competency. I place particular emphasis on the development of the medical specialty of gynecology in the United States as a modality to address the need for historical truth-telling in medical schools.

Finally, Part IV concludes that CRF Bioethics should be explored to adequately address the necessity of telling the "her-storical" narratives of Anarcha, Betsey, and Lucy in order to center the so-called "objects" of experimentation in medical history and reclaim their humanity to achieve cultural competency presently.

I. NARRATIVE IN LAW AND NARRATIVE IN MEDICINE

The relationship between the vestiges of enslavement, race, and social constructions of race, and their impact on the quality of healthcare of diverse populations, particularly as to African Americans, is well documented.[20] However, the use of storytelling

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[20] *See* HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 17–18 (2006) [hereinafter WASHINGTON, MEDICAL APARTHEID]. According to Random House, Inc., *Medical Apartheid* provides the "first and only comprehensive history of medical experimentation on African Americans." Random House, Inc., Medical Apartheid, http://www.randomhouse.com/catalog/display.pperl/9780767915472.html (last visited June 20, 2009). *See generally* W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE: BEGINNING TO 1900 (2000) (according to United States Congressman John Conyers, Jr. "*An American Health Dilemma* offers a wealth of information on the role race plays in health

and narrative jurisprudence as a teaching modality in law[21] and, most recently, in medicine[22] lays the foundation for giving voice to the historically silenced, existing in the background but never center stage, no matter how integral to the ultimate story. [23]

The evolving discourse on the notion of "applied legal storytelling,"[24] "legal archaeology,"[25] and the role of narrative in

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delivery in America. This long overdue work is the first comprehensive explanation of how the race and class-based health disparities evolved in the United States . . . . A must-read for anyone interested in correcting the existing inequalities in the current health system." (quoting Barnes & Noble, The American Health Dilemma: Editorial Reviews, http://search.barnesandnoble.com/The-American-Health-Dilemma/W-Michael-Byrd/e/9780415924498 (last visited June 20, 2009))); TODD L. SAVITT, MEDICINE AND SLAVERY: THE DISEASES AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA (1978) (discussing the history of health and health care among Black Americans).

[21] *See* Delgado *supra* note 19, at 2440–41. The Author notes the existence of oppositionists to the storytelling movement in law. *See generally* DERRICK BELL, AND WE ARE NOT SAVED: THE ELUSIVE QUEST FOR RACIAL JUSTICE (1987) (using storytelling to examine the legal and cultural barriers to equality); Derrick Bell, *After We're Gone: Prudent Speculations on America in a Post-Racial Epoch*, 34 ST. LOUIS U. L.J. 393, 397–400 (1990) (utilizing a fictional *Chronicle of the Space Traders* to illustrate the historical treatment of Blacks). *Contra* Daniel A. Farber & Suzanna Sherry, *Telling Stories out of School: An Essay on Legal Narratives*, 45 STAN. L. REV. 807, 809 (1993) (expressing the point of view that legal scholarship contain reason and analysis beyond emotive appeal). *See generally* Jane B. Baron, *Resistance to Stories*, 67 S. CAL. L. REV. 255 (1994) (providing an excellent critique on the resistance to legal storytelling).

[22] *See* Stacey A. Tovino, *Incorporating Literature Into A Health Law Curriculum*, 9 J. MED. & L. 213, 213–15 (2005) (noting literature's "long relationship with [both] medicine [and law] through literary images of disease[s], . . . physicians . . . and the use of literature as a method of active or passive healing . . . literary images of various legal processes, lawyers, and judges . . . and the use of literature as therapy"). *See generally* Paul A. Lombardo, *Teaching Health Law: Legal Archaeology: Recovering the Stories behind the Cases*, 36 J.L. MED. & ETHICS 589, 589 (2008).

Lombardo points out:

> The fields of biomedical ethics and medical humanities have seen a burgeoning literature in the area of "narrative medicine" that uses the skills of storytelling, along with attention to literary genres incorporating myth, legend, and the personal essay to better understand the relationships of patients and their doctors and to enrich the clinical practice of medicine.

[23] *See* Washington, *supra* note 12, at 127. I have asserted that a "CRF Perspective is integral to . . . the Black woman's unique experiences and her interaction with the law; otherwise, 'her-story' would not be . . . worthy of being told." *See generally* PATRICIA WILLIAMS, THE ALCHEMY OF RACE AND RIGHTS 225–27 (1991) (Patricia Williams recognizes the historical interpretation of enslaved Black women as property amounting to the devaluation of the notion of personhood and ultimate dehumanization).

[24] Ruth Anne Robbins, *Harry Potter, Ruby Slippers and Merlin: Telling the Client's Story Using the Characters and Paradigm of the Archetypal Hero's Journey*, 29 SEATTLE U. L. REV. 767, 771 (2006) (Robbins defines the term Applied Legal Storytelling as "pertain[ing] to ideas of how everyday lawyers can utilize elements of mythology as a persuasive technique in stories told directly to judges—either via . . . legal writing documents such as briefs—on behalf of an individual client in everyday litigation."). *See generally* Brian Foley, *Applied Legal Storytelling, Politics, and Factual Realism*, 14 J. LEGAL WRITING INST. 17, 17 (2008) (Foley notes that the first Applied Legal Storytelling conference, Once Upon a Legal Time: Developing the Skills of Storytelling in Law held in London on July 18–20, 2007 was realized

law[26] provides both lawyers and law professors with an opportunity to explore the ultimate goals[27] for telling the story and enhancing the ability of the storyteller "to see law as narrative or storytelling."[28] The proponents of utilizing narrative and storytelling to develop legal skills and lawyering often begin with an extrapolation of the traditional terms of art associated with storytelling, such as the "character, conflict, resolution, organization, point-of-view," and, perhaps, setting.[29] I argue that the notion of "traditional" must be viewed through a "her-storical" lens in order to see the marginalization of "raced and gendered race"[30] characters in the story being retold. Narratives and stories

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in part, "because the . . . organizers wished to create a sustainable dialogue about the application of storytelling elements to the practice and pedagogy of law.").

As a presenter at this historic conference, I bear witness to the opportunity that the Storytelling conference provided during the commemorative year 2007 which marked the end of the slave trade in Britain, as a venue to not only engage in scholarly dialogue about the "stories" that are told, but also shed light on the "stories" that are not told at all or marginalized at best, which I refer to as the *narrative behind the narrative* and will discuss more fully below.

[25] Judith L. Maute, *Response: The Values of Legal Archaeology*, 2000 UTAH L. REV. 223 (1999–2000); Deborah L. Threedy, *Legal Archaeology: Excavating Cases, Reconstructing Context*, 80 TUL. L. REV. 1197, 1197 (2006).

[26] Richard A. Matasar, *Storytelling and Legal Scholarship*, 68 CHI.-KENT L. REV. 353, 361 (1992); Philip N. Meyer, *Making the Narrative Move: Observations Based Upon Reading Gerry Spence's Closing Argument in* The Estate of Karen Silkwood v. Kerr-McGee, Inc., 9 CLINICAL L. REV. 229, 231 (2002) (Meyer argues that to "make the narrative move" there is the necessity for story-structure and a well-constructed plot, for character, for conflict and resolution, all controlled by the constraints of the evidence and the rules of law, the evidentiary genre conventions of storytelling at trial, and the narrative logic).

[27] *See* Delgado, *supra* note 19, at 2413 (Delgado notes that "[s]tories, parables, chronicles, and narratives are powerful means for destroying [the] mindset—the bundle of presuppositions, received wisdoms, and shared understandings against a background of which legal and political discourse takes place"); Martha-Marie Kleinhans, *Rewriting "Outsider" Narratives: A Renaissance of Revolutionary Subjectivities*, 2 CHARLESTON L. REV. 185, 188–89 (2007). Klienhans argues that: "As a narrative strategy, storytelling in outsider jurisprudence [can] be assessed on the first two themes in terms of its genre; as a political strategy . . . [and] in terms of both its aspirations and perceived effectiveness."

[28] Susan Ayres, *The Power of Stories: Gloucester Tales*, 12 TEX. WESLEYAN L. REV. 1 (2005-2006) (providing an overview of the active role of literature in the law). *See generally* Marcia Canavan, *Using Literature to Teach Legal Writing*, 23 QUINNIPIAC L. REV. 1, 15–21 (2004) (utilizing storytelling techniques to teach legal writing students); Delgado, *supra* note 19, at 2440–41 (describing the benefits of infusing storytelling into legal writing); Kim Lane Scheppele, *Foreword: Telling Stories*, 87 MICH. L. REV. 2073, 2075 (1989) (author sums up the reason for storytelling as "[t]o make sense of law and to organize experience, people often tell stories. And these stories are telling").

[29] Brian J. Foley & Ruth Anne Robbins, *Fiction 101: A Primer for Lawyers on How to Use Fiction Writing Techniques to Write Persuasive Facts Sections*, 32 RUTGERS L.J. 459, 466 (2001) (addressing the gap in a lawyers' need to tell a good story particularly in the facts section of briefs and memoranda and the notable absence of legal writing textbooks which provide the necessary techniques of how to craft a good legal story); *see* Canavan, *supra* note 29, at 12.

[30] Margaret Montoya, *Defending the Future Voices of Critical Race Feminism*, 39 U.C.

energize legal theory[31] due to their ability to hear a multiplicity of voices emanating from the storyteller and moving the story listener.

The illusive "other voice" that is being searched for can be found in the acknowledgement of a "multiple consciousness"[32] capable of speaking in many voices. In the tradition of Critical Race Feminist[33] theorists, the notion of storytelling and narrative analysis serves as a "bridge toward understanding the legal status of women of color and the ways in which women of color face multiple discrimination on the basis of factors, including but not limited to race, gender, class, able-bodiedness, and sexuality"[34] by hearing the multiple voices of those "characters" marginalized in history and at present.

Professor Margaret Montoya sent out a call to action in her moving article, *Defending The Future Voices Of Critical Race Feminism*,[35] when she concluded that "[t]he fusion of CRF from law schools with linguistic and cultural competence from medical schools is an idea worth pursuing."[36] The laws of enslavement and the resulting "slave health deficit"[37] present complex narratives that have yet to be adequately examined in light of current day health disparities among Blacks. Byrd and Clayton found that "African Americans have always been aware of the United States' health system's race and class problems through their traditional interface with the system."[38] It is this history that must be acknowledged and discussed, because, as Toni Morrison put it, "in spite of its implicit and explicit acknowledgment, 'race' is still a virtually unspeakable thing."[39] A CRF analysis of medical advancements in gynecology, which embodies the laws of enslavement, is a story worth being told. Professor Pamela Bridgewater correctly argues that "[s]lavery was not just about chains and forced labor as the

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DAVIS L. REV. 1305, 1319 (2006) (describing examples of the areas of scholarship for CRF).

[31] *See* Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 608 (1990) (noting that writer and activist bell hooks "describes her experience in a creative writing program at a predominately white college, where she was encouraged to find 'her voice,' as frustrating to her sense of multiplicity").

[32] *See* Mari J. Matsuda, *When the First Quail Calls: Multiple Consciousness as Jurisprudential Method*, 14 WOMEN'S RTS. L. REP. 297 (1989).

[33] *See generally* WING, *supra* note 18, at 1.

[34] Angela Onwuachi-Willig, *Foreword: This Bridge Called Our Backs: An Introduction to "The Future of Critical Race Feminism"* 39 U.C. DAVIS L. REV. 733, 736 (2006).

[35] Montoya, *supra* note 31, at 1319.

[36] *See id.* at 1314.

[37] BYRD & CLAYTON, *supra* note 21, at 194.

[38] *Id.* at 15.

[39] Toni Morrison, *Unspeakable Things Unspoken: The Afro-American Presence in American Literature*, 28 MICH. Q. REV. 1, 3 (1989).

traditional story suggests– [sic] it was about the gendered forms of bondage which had particular consequences in the lives of women. Female slaves had a slavery all their own– [sic] specifically designed to exploit what the institution valued in their bodies."[40] This article focuses on telling the story of medical value and gynecological advancement resulting from the reproductive and sexual exploitation of Black women during enslavement as a step toward cultural competency.

A. Narrative in Medicine

Dr. Rita Charon has led the exploration of narrative analysis in medicine. Dr. Charon posits that "[t]he rise of narrative medicine may signify fundamental changes in the experience of disease or of doctoring. It also suggests that medicine, as part of its culture, is responding to the forces propelling similar narrative turns in such fields as literary studies, history, qualitative social sciences, and ethics."[41] Dr. Charon advocates focusing on "the textual and singular dimensions of illness by paying attention to patients' (and doctors') stories and their meanings" in order to practice "narratively competent" medicine.[42] She has identified at least five genres of narrative writing in medicine; namely "Medical Fiction" (invented stories about physicians and patients), "The Lay Exposition" (lay public stories about medicine), "Medical Autobiography" (doctor stories about "doctorly acts"), "Stories from Practice" (physician to physician stories), and "Writing Exercises of Medical Training" (trainees' reflective stories on their patients' experiences as well as their own personal experiences).[43] The fundamental objective for each genre of Charon's narrative writing in medicine requires the attainment of the techniques and skills of both a storyteller and a story listener, which is consistent with the storytelling movement in legal practice and pedagogy.

In the case of the development of gynecology, Dr. Charon's "Medical Autobiography" is illustrated in the memoir of Dr. J.

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[40] Bridgewater, *Un/Re/Dis Covering*, *supra* note 10, at 43.

[41] Rita Charon, *Narrative Medicine: Form, Function and Ethics*, 134 ANNALS OF INTERNAL MED. 83, 83 (2001) [hereinafter Charon, *Narrative Medicine*]. Dr. Rita Charon coined the term "narrative medicine" to convey "medicine practiced with the narrative competence to recognize, interpret, and be moved to action by the predicaments of others." *Id.*

[42] Rita Charon, *Literature and Medicine: Origins and Destinies*, 75 ACAD. MED. 23, 26. Charon acknowledges the similarities between literature and medicine as evidenced by the medical profession's need to "turn . . . toward a medicine that is both technologically and narratively competent." *Id.* at 23.

[43] *See* Charon, *Narrative Medicine*, *supra* note 42, at 83–84.

Marion Sims[44]—historically referred to as the "Father of Modern Gynecology"[45] and the "Architect of the Vagina."[46] Dr. Sims's memoir, which has served as the seminal exposition on the medical specialty of gynecology in the United States, calls for a critical examination to illuminate the *narrative behind the narrative.* This *narrative behind the narrative* is the side of the medical story that is marginalized and oftentimes intentionally overlooked, but located in the space where missing "characters" oftentimes exist—yet are silenced[47] by historical slants to achieve a desired outcome: the development of science and technology.

1. The Medical Narrative of Gynecology

The title of Dr. J. Marion Sims's memoir, *The Story of My Life,* written in 1884 and reprinted in 1968, is indicative of author Elizabeth Lyon's observation that "[t]itles offer an important reflection the slant."[48] The slant of Sim's book is unmistakably "his-story" written from his "written memory," and represents his interior life.[49] It is the medical story of the development of the specialty of gynecology that has become a memoir outside of Sims's interior life,[50] yet they are inextricably bound together, primarily due to his notoriety for discovering a cure for "vesico-vaginal fistula, a medical condition involving internal tears in the vaginal wall leading to urinary and sometimes fetal incontinence, most often

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[44] *See* SIMS, *supra* note 7.

[45] Washington, *supra* note 12, at 130.

[46] *Id.*

[47] *See generally* Cheryl I. Harris, *Finding Sojourner's Truth: Race, Gender, and the Institution of Property,* 18 CARDOZO L. REV. 309, 317 (1996) (discussing race and gender using Sojourner Truth as a lens). Cheryl I. Harris puts it this way:

> Locating the voice of Sojourner Truth is complicated by the fact that as a Black woman, racial and gender hierarchies placed her outside the category of "Woman." Precisely because of a Black woman's location at the margins—because she stood so far outside the normative structures of dominant society—any intervention she made was subject to being overlooked, misheard, misinterpreted, misrepresented and ultimately, misappropriated.

Id.

[48] ELIZABETH LYON, NONFICTION BOOK PROPOSALS ANYBODY CAN WRITE: HOW TO GET A CONTRACT AND ADVANCE BEFORE WRITING YOUR BOOK 24 (Blue Heron Publishing 1995) (defining slant as "the focus of your subject or the angle you take in presenting it").

[49] *Id.* at 81 (Philip Gerard, author of *Creative Nonfiction: Researching and Crafting Stories of Real Life,* defines memoir as follows: "[It] strikes the same emotional note as autobiography—written memory—but is usually focused on some triggering person or event in the narrator's experience . . . memoir is always a memoir *of* something outside the narrator's interior life.").

[50] *Id.*

caused during traumatic childbirth."[51] A glimpse of Sims's interior life can be gleaned from the federal census of 1850 wherein Sims is recorded as the owner of seventeen slaves when he lived in Montgomery, Alabama.[52]

However, the 1968 foreword of Sims's memoir written by Professor and Physician C. Lee Buxton of Yale Medical School provides insight as to the historically-accepted profile of the main character of this medical story:

> Few Americans have made so great an impression on their special world as J. Marion Sims did on American and European medicine in the middle and late years of the nineteenth century. Dynamic, vital, imaginative, sometimes contentious, always filled with dedication to a burning mission, this ever gentlemanly physician, by professional and personal attributes of permanent quality, helped create gynecology as a specialty . . . . Such is the transitory nature of fame, however, that were it not for the eponyms of the "Sims' speculum"[53] and "Sims'[54] position," Marion Sims might be little known today except to those interested in the history of American medicine. Sims is not only America's first gynecologist but undoubtedly its most important one.[55]

The noted "drawback" requiring the presence of assistants—preferably "skilled" assistants[56] in order to use the Sims speculum—can provide historical context for the doctor/teacher-medical

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[51] *See* Washington, *supra* note 12, at 129 (quoting DEBORAH KUHN MCGREGOR, FROM MIDWIVES TO MEDICINE: THE BIRTH OF AMERICAN GYNECOLOGY 33 (Rutgers University Press 1998)); L. Lewis Wall, *Did J. Marion Sims Deliberately Addict His First Fistula Patients to Opium?*, 62 J. HIST. MED. & ALLIED SCI. 336, 337 (2007) (defining vesico-vaginal fistula as "a catastrophic complication of childbirth from prolonged obstructed labor in which a hole opens up between a woman's bladder and her vagina, resulting in continuous and unremitting urinary incontinence").

[52] *See* SCHWARTZ, *supra* note 13, at 237 (noting that Sims did not only "treat" enslaved women but he "owned" them, some of which were purchased for purposes of experimentation).

[53] *See* ALFRED LEWIS GALABIN, THE STUDENT'S GUIDE TO THE DISEASES OF WOMEN 22 (1884) (defining Sims' Speculum as: "Sims' univalve speculum is far superior to all others for many purposes, as when it is desired to introduce a tent or probe through the speculum, or to operate upon the cervix or vaginal walls. Its drawback is that *it cannot be employed without an assistant, while a skilled assistant is necessary to give it its full value.*" (emphasis added)).

[54] *Id.* (noting that "[S]he lies on her left side, in a semi-prone position, with the head and shoulders low, and the left arm drawn behind her, so that the sternum is rotated forwards, coming very nearly into contact with the table. The legs are flexed at right angles to the trunk, and the right rather that the left, so that the right knee lies just above the left, in contact with the table . . . .").

[55] SIMS, *supra* note 7, at v.

[56] *Id.* at 243 (Sims trained the enslaved women to assist each other after his medical assistants and local doctors grew tired of his repeated failures after more than three years of experiments).

assistant/student clinical model for modern day medical residency training programs. The latter are among the many beneficiaries of an under-discussed level of interdependency between slavery and medical advancement that set the stage for the notion of "science" and "technology" explored in this article.[57]

The institutional memory of the man, Sims's name is historically synonymous with the development of gynecology in the United States.[58] In his own words, Sims tells how he discovered the cure for vesico-vaginal fistula:

> With a palpitating heart and an anxious mind I turned her [Anarcha] on her side, introduced the speculum and there lay the suture apparatus just exactly as I had placed it. . . . This was in the month of May (1849). In the course of two weeks Lucy and Betsy were both cured by this same means without any sort of disturbance or discomfort. Then I realized the fact that at last my efforts had been blessed with success and that I had made, perhaps, one of the most important discoveries of the age for the relief of suffering humanity.[59]

Sims's "discovery" and the ultimate resolution of his story has led to either a justification of the end result—scientific medical advancement in the area of gynecology, innovative surgical instrumentation and procedures currently used in contemporary gynecology, or a critical analysis of the means—human experimentation of an enslaved group of Black women over four years.[60]

Sims published his postoperative treatment of the fistula patients

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[57] For a visual depiction of a "Revisionist History" see Robert Thoms' 1961 oil painting, entitled "J. Marion Sims: Gynecologic Surgeon" depicting Sims standing with folded arms, and two medical students standing behind who is known as Lucy, in what has been categorized as the Sims hand-knee position [with Anarcha and Betsey looking from behind the curtain]. The Alabama enslaved women who were about to be experimented upon are portrayed as fully clad in "ladies" apparel perhaps to define their gender and without shoes to indicate their condition of enslavement. The picture demonstrates the doctor in a position of authority equipped with his instrument (speculum) while the students stand prepared to assist. George A. Bender with Artist Robert A. Thom, *History of Medicine in Pictures* (Parke Davis, 1961); *see* MCGREGOR, *supra* note 52, at 44 and cover book illustration.

[58] MCGREGOR, *supra* note 52, at 44.

[59] *Id.* at ix.

[60] Washington, *supra* note 12, at 130 & n.30 (citing Terry Andrea Kapsalis, The Pelvic Exam as Performance: Power, Spectacle, and Gynecology (1994) (unpublished Ph.D. dissertation, Northwestern University) (on file with Northwestern University Library) ("describing the praise in medical history texts that Dr. Sims received for his contributions to contemporary gynecology despite his cruel use of enslaved women as" subjects of human experimentation).

in an article entitled "On the Treatment of Vesico-vaginal Fistula" in 1852, wherein he opines:

> Old fistula cases are generally used to opium; and where they are not, they soon learn its beneficial effects. It calms the nerves, inspires hope, relieves the scalding of the urine, prevents a craving for food, produces constipation, subdues inflammatory action, and assists the patient, doomed to a fortnight's horizontal position, to pass the time with pleasant dreams, and delightful sensations, instead of painful forebodings, and intolerable sufferings.[61]

The reality of whether a "conflict"[62] exists in the medical narrative of gynecology often lies in the telling of the medical story. As Professor and Physician L. Lewis Wall tells it:

> Sims developed his technique for fistula repair by carrying out a series of experimental operations between early 1846 and the summer of 1849 on a group of enslaved African American women with fistulas who had been given to him by their owners for this purpose. In his writings, Sims consistently maintained that he obtained the consent of these women prior to operating on them, that he promised their owners that he would perform no experiment or operation on them that endangered their lives, and also that he would pay for all of their living expenses while they were under his care. Eventually, these women learned to assist Sims in surgery, helping him operate on each other in turn, until he finally succeeded in repairing their injuries. At the time Sims began his therapeutic surgical experiments on these women, ether anesthesia was as yet unknown. After the anesthetic properties of ether were discovered in late 1846, Sims—like many other American and European surgeons of that time—did not embrace it.[63]

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[61] J. Marion Sims, *On the Treatment of Vesicovaginal Fistula*, 23 AM. J. MED. SCI. 80–81 (1852).

[62] Elizabeth Fajans & Mary R. Falk, *Untold Stories: Restoring Narrative To Pleading Practice*, 15 J. LEGAL WRITING INST. 3, 18 (2009) (noting that "Although the components of narrative are stable, the nature of the trouble or conflict varies. It may stem from conflict with another, from conflict within the self, or from conflict with society. But whatever the trigger, the conflict arises out of a disjunction between the 'Agent, Act, Purpose (or Goal) and Agency (or Means) and Scene.'"). Here the conflict arises from a disjunction between Sims' goal to discover a cure for vesico-vaginal fistula and the means of subjecting enslaved Black women to not only four years of a series of experiments without anesthesia but also to the subsequent trial and error of his ultimate surgical inventions and instruments.

[63] Wall, *supra* note 52, at 337–38; *See also* L. L. Wall, *The medical ethics of Dr J Marion Sims: a fresh look at the historical record*, 32 J. MED. ETHICS 346–50 (2006) (arguing that the

A critical examination of the medical story's setting, the nineteenth century[64] slave-holding state of Alabama, provides a socio-cultural context[65] for discussion of how race, gender, class, law, and the pursuit of medical knowledge intersected then and presently in diverse communities, representative of historically disadvantaged populations.

Wilma King points out that:

> [s]lave women often became pregnant through forced cohabitation and molestation by white men. While proslavery critics charged abolitionists with using stories of sexual exploitation to politicize their cause, African-American slaves passed down these accounts from one generation to another as the truth. The pregnant slave woman received no prenatal care, endangering the lives of the expectant mother and her unborn child. Generally ignorant about their bodily functions and needs during gestation, slave women did not own their own persons; nor did they have resources to assure a healthy pregnancy or safe delivery.[66]

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ethical criticisms of J. Marion Sims and his practices are "attacks . . . not substantiated by the primary historical sources relating to the case, nor [the modern writers'] charges consistent with any deep clinical understanding of the predicament faced by women who have developed a vesicovaginal fistula from obstructed labour . . . ."). However, it should be noted here that primary sources indicate that Sims did administer opium to the enslaved women post-operatively. *See* SIMS, *supra* note 62; *see also* Wall, *supra* note 52 (examining the controversy surrounding Sims' use of postoperative opium in these enslaved surgical patients).

[64] Marci Bounds Littlefield, *Black Women, Mothering, and Protest in 19th Century American Society*, 2 J. PAN AFR. STUD. 53, 56 (2007). Dr. Marci Bounds Littlefield points out that:

> Black women were important not only for their labor, but for their reproductive ability, a vital part of the slave economy; they were solely responsible for supplying the slave work force and, in many ways, these women were the most vulnerable and valuable group. Black women were a commodity as breeders, laborers, and concubines, but their motherhood was not separated from their slave status.

See generally DEBORAH GRAY WHITE, AREN'T I A WOMAN: FEMALE SLAVES IN THE PLANTATION SOUTH (1985).

[65] Wilma King, *"Suffer With Them Till Death" Slave Women and Their Children in Nineteenth-Century America*, *in* MORE THAN CHATTEL: BLACK WOMEN AND SLAVERY IN THE AMERICAS 147 (David Barry Gasper & Darlene Clark Hine eds., 1996). *See generally* DAINA BERRY, SWING THE SICKLE FOR THE HARVEST IS RIPE: GENDER AND SLAVERY IN ANTEBELLUM GEORGIA (2007) (examining how labor and economy shaped the family life of bondwomen and bondmen in the antebellum South).

[66] King, *supra* note 66, at 148; Caroline Elizabeth Neely, *"Dat's one chile of mine you ain't never gonna sell": Gynecological Resistance within the Plantation Community* (thesis submitted to the Faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of Master of Arts in History, May 18, 2000) (noting that "[i]n addition to the sexual abuse that slave women had to endure, bondwomen

The enslaved Black women's body was forced by the laws of society to produce wealth—material as well as a body of medical knowledge.

2. The "Narrative behind the Narrative" of Anarcha, Betsey, and Lucy

The narrative of the enslaved woman's labor in the field, in the house, and in the margins of the medical history of gynecology in the United States is yet to be adequately explored.[67] Morgan argues that:

> Slaveowners contemplated women's reproductive potential with greed and opportunism, they utilized both outrageous images and callously indifferent strategies to ultimately inscribe enslaved women as racially and culturally different while creating an economic and moral environment in which the appropriation of a woman's children as well as her childbearing potential became rational and, indeed, natural.[68]

This rationale is exemplified when critically examining medical advancement and the experimentation of the female body, albeit Black and enslaved. The foundation for the development of the medical specialty of gynecology in the United States spans from 1845. At this time, Alabama prohibited enslaved Africans to read or write.[69] Therefore, Anarcha, Betsey, and Lucy were legally prohibited from describing in their own words their experiences as the objects of medical experimentation. According to Sims's memoir, the three named enslaved Black women were among at

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had to deal with issues involving pregnancy and motherhood"). This article places particular emphasis on the attendant complications of pregnancy, resulting in the development of the medical specialty of gynecology.

[67] MORGAN, *supra* note 11, at 6 (Morgan points out that "[t]he connections between commodification, production, and reproduction are nowhere as clear, nor as unexplored, as in African American history.").

[68] MORGAN, *supra* note 11, at 7; *see* Thelma Jennings, *"Us Colored Women Had to Go Through A Plenty": Sexual Exploitation of African-American Slave Women*, 2 J. WOMEN'S HIST. 44–74 (1990) (noting the particular inequalities faced by the status of a female enslaved woman in the patriarchal institution of slavery in the Old South).

[69] *See generally* JOHN HOPE FRANKLIN & ALFRED A. MOSS, JR., FROM SLAVERY TO FREEDOM: A HISTORY OF AFRICAN AMERICANS 136–37 (Alfred A. Knopf ed., 1994) (1947) (describing the education of slaves before the Civil War); Peggy Cooper Davis, *Contested Images of Family Values: The Role of the State*, 107 HARV. L. REV. 1348, 1361 (1994) (suggesting that "[s]lavery in the United States was justifiable only on the assumption that the enslaved race lacked the will or capacity for autonomous existence. Proponents of slavery were therefore armed with arguments that African-Americans were neither troubled by restraint nor qualified for moral and intellectual freedom.").

least twelve unnamed women identified collectively as "patients" [70] and subjected to a "series of experiments" to cure their medical condition of vesico-vaginal fistula.[71] The experiments were conducted on a rolling basis, as Sims invented and perfected his surgical instruments with the first operation commencing "on the __ day of December, 1845," and ending in "June (1849)."[72] The "her-story" of Anarcha, Betsey, and Lucy, as documented in Sims's memoir, coupled with the written and unwritten history of particularized experiences,[73] sustained by the Black woman's body during enslavement, "would furnish material for epics."[74]

The beginning of Anarcha, Betsey, and Lucy's story is contextualized by the notion of fitness for duties[75] for enslaved women in nineteenth century Montgomery, Alabama. The peculiar institution of slavery in the United States extracted a unique form of labor from enslaved Black women, that is "[h]istorically [they] were encouraged and often forced to have babies in order to create and maintain a cash crop of human labor . . . ."[76] In other words, the "duty" of an enslaved Black woman earned her the historical status of breeder woman.[77]

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[70] SIMS, *supra* note 7, at 236. According to Sims, he "ransacked the country for cases . . . ended [his] finding six or seven cases of vesico-vaginal fistula that had been hidden away for years in the country because they had been pronounced incurable. [He] went to work to put another story on [his] hospital . . . four beds for servants, and twelve for the patients." *Id.* *See* SCHWARTZ, *supra* note 13, at 237 (noting that "[a]ccording to the Federal Census of 1850, Sims claimed seventeen slaves when he lived in Montgomery, Alabama, twelve of whom were female").

[71] SIMS, *supra* note 7, at 239.

[72] *Id.* at 239–46.

[73] Washington, *supra* note 12, at 128 (arguing that "'[h]er-story,' the Black woman's story, cannot be maintained in the background of history. The Black woman's body has known reproductive regulations and reproductive restraints. Her womb has been used as a reproductive resource center and as a receptacle or dumping ground for the sexual pleasure of those in power." (internal footnotes omitted)).

[74] THE VOICE OF ANNA JULIA COOPER: INCLUDING *A VOICE FROM THE SOUTH* AND OTHER IMPORTANT ESSAYS, PAPERS, AND LETTERS 202 (Charles Lemert & Esme Bhan eds., 1998) (excerpted from Anna Julia Cooper's address at the World's Congress of Representative Women in Chicago held on May 18, 1893, wherein she speaks to the depth of untold "stories" of the enslaved Black woman's location in history).

[75] *See* SIMS, *supra* note 7, at 227 (describing the women as "young" and "well developed").

[76] Washington, *supra* note 12, at 129 (citing Bernier, *supra* note 10, at 128); *see also* ROBERTS, *supra* note 20, at 22–28 (describing the slave owners' control over their slaves' reproduction). For a comparison of the breeding system of United States Slavery to the non-breeding system of Brazilian slavery, see generally, CARL N. DEGLER, NEITHER BLACK NOR WHITE: SLAVERY AND RACE RELATIONS IN BRAZIL AND THE UNITED STATES (1971) (Degler points out that "[s]lave breeding on the scale achieved in the United States was not important to Brazilian slaveholders. Stanley Stein, for example, discovered a genuine reluctance among slaveholders in Vassouras to bother with breeding and rearing slaves").

[77] Bridgewater, *Ain't I A Slave*, *supra* note 11, at 120–21 (footnotes omitted).

Bridgewater points out:

> The historians who describe slave breeding suggest that it was akin to animal husbandry. It consisted of a concerted effort to increase the number of slave holdings by forcing female slaves to reproduce. Several methods were used to facilitate increased reproduction rates. Some slave owners identified slaves for breeding and paired them. Others sold good breeders to the market. Still others were personally involved in the breeding process via rape of their slaves.[78]

This article explores the under-discussed collateral consequences of breeding, such as Sims's role as doctor to enslaved Black women, resulting in a socially constructed lens toward the end result of "fixing" so-called property in order to reproduce.[79] Although the *narrative behind the narrative* lies in the collective experiences of Anarcha, Betsey, and Lucy, a CRF lens allows the story listener to empathize with their individual stories.

a. Anarcha's Story—"Silver Sutures"

Sims told Mr. Westcott, the enslaver of Anarcha, "a young colored woman, about seventeen years of age, well developed, who had been in labor then seventy-two hours,"[80] after diagnosing her case as "hopelessly incurable," that "Anarcha ha[d] an affection that unfit[] her for the duties required of a servant."[81] On Anarcha's thirtieth operation during a four-year period of a series of experiments utilizing silk thread to suture the fistulas, Sims states:

> I was walking from my house to the office, and picked up a little bit of brass wire in the yard. It was very fine, and such as was formerly used as springs in suspenders before the days of India-rubber. I took it around to Mr. Swan, who was then my jeweler, and asked him if he could make me a little silver wire about the size of the piece of brass wire. He said Yes, and he made it. . . . The operation was performed on the

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[78] *Id.*

[79] *See* SIMS, *supra* note 7, at 227. (referring to Sims' diagnosis of Anarcha's female condition as rendering her unfit for servant duties).

[80] SIMS, *supra* note 7, at 226–27. Mr. Wescott lived only a mile from Montgomery. In June 1845, Dr. Henry called Sims "to go out to Mr. Wescott's . . . to a case of labor which had lasted three days and the child not yet born." *Id.* The case was Anarcha's and Sims used forceps to deliver her child. *Id.* However, five days later Anarcha experienced loss of "control of both [her] bladder and the rectum" due to "an enormous slough, spreading from the posterior wall of the vagina, and another thrown off from the anterior wall." *Id.*

[81] *Id.* at 227.

> fistula in the base of [Anarcha's] bladder, that would admit of the end of my little finger. . . . The edges of the wound were nicely denuded, and neatly brought together with four of these fine silver wires. They were passed through little strips of lead, one on one side of the fistula, and the other on the other. The suture was tightened, and then secured or fastened by the perforated shot run on the wire, and pressed with forceps. . . . With the use of the silver suture there was a complete change in . . . condition.[82]

b. Lucy's Story—"The Speculum"

"Lucy, about eighteen years old had given birth to child two months ago," a servant of Mr. Tom Zimmerman, of Macon County[83] was maintained by Sims after he conducted an examination of Mrs. Merrill, a white woman "about forty–six years of age, stout and fat, and weighed nearly two hundred pounds" who fell from her pony with all her weight on the pelvis.[84] In order to "relocate the uterus"[85] Sims had the woman assume a position on her knees and elbows[86] to effectuate the digital examination, which ultimately relieved the pressure. As to Lucy, Sims states:

> [I]f I can place the patient in that position, and distend the vagina by the pressure of air, so as to produce such a wonderful result as this, why can I not take the incurable case of vesico-vaginal fistula, which seems now to be so incomprehensible, and put the girl in this position and see exactly what are the relations of the surrounding tissues? . . . Passing by the store of Hall, Mores & Roberts, I stopped and bought a pewter spoon. I went to my office where I had two medical students, and said, "Come, boys, go to the hospital with me." . . . I said, [Lucy], I told you that I would send you home this afternoon, but before you go I want to make one more examination of your case." She willingly consented. I got a table about three feet long, and put a coverlet upon it, and mounted her on the table, on her knees, with her head resting on the palms of her

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[82] *Id.* at 244–45 (Sims categorizes this section of his memoir as "Success of the Silver Suture").

[83] *Id.* at 228–29.

[84] *Id.* at 231.

[85] TERRI KAPSALIS, PUBLIC PRIVATES: PERFORMING GYNECOLOGY FROM BOTH ENDS OF THE SPECULUM 37 (Duke University Press, Durham and London 1997).

[86] *Id.*

> hands . . . . Introducing the bent handle of the spoon I saw everything, as no man had ever seen before. The fistula was as plain as the nose on a man's face.[87]

c. Betsey's Story—"Self-retaining Catheter"

"Betsey, a young woman seventeen or eighteen years old, married last year, [and who] had a baby about a month ago" was the servant girl of Dr. Harris from Lowndes County[88] and was next to be operated on following Lucy's recovery of what Sims referred to as an "unfortunate experiment."[89] Sims placed a "little piece of sponge into the neck of [Lucy's] bladder, running a silk string through it"[90] which resulted in the whole urethra and neck of the bladder becoming inflamed, and Sims's act of pulling it away by main force while acknowledging that "Lucy's agony was extreme. . . . [B]ut by irrigating the parts of [her] bladder she recovered with great rapidity, and in the course of a week or ten days was as well as ever."[91] As to Betsey, Sims's states:

> As soon as I had arranged a substitute for the sponge, I operated on Betsey. . . . The fistula occupied the base of the bladder, and was very large, being quite two inches in diameter. I repeated the operation, in the same way and manner as performed on Lucy, with the exception of placing in the bladder a self-retaining catheter, instead of the sponge. . . . Seven days rolled around; [Betsey] had none of the chills or fever, either violent or sudden, or the disturbance attending the previous operation. At the end of seven days the sutures were removed. To my great astonishment and disappointment, the operation was a failure.[92]

A most glaring area of conflict in the medical story on the development of gynecology lies in the notion that the enslaved Black women's body was Sims's "experimental property not only in the operation stage, but also during the post-operative healing process."[93] Even the necessity of an operation for the condition of

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[87] SIMS, *supra* note 7, at 234–35.
[88] *Id.* at 228.
[89] *Id.* at 238.
[90] *Id.* at 237.
[91] *Id.* at 238.
[92] *Id.* at 239–40.
[93] Washington, *supra* note 12, at 131 n.37.

vesico-vaginal fistula has been questioned by modern writers.[94] Sims claimed that the surgical operations on the enslaved Black women for vesico-vaginal fistula was "not painful enough to justify the trouble [of anesthetic] and risk attending the administration."[95] As to the operation stage, Sims reconciles "that was before the days of anesthetics, and the poor girl [Lucy], on her knees, bore the operation with great heroism and bravery."[96] However, McGregor notes that "[w]hite women with vesico-vaginal fistulas who came to Sims in 1849 . . . were unable to withstand the same operation without anesthesia."[97] The difference in treatment speaks volumes to those marginalized both past and present. Sims's postoperative treatment of providing the enslaved women with opium is a source of conflict based on the telling of the story and the predisposition to see and hear the *narrative behind the narrative*.[98]

As Byrd and Clayton tell it:

> Sims exploited both Black slaves and poor White women to further his surgical career. He purchased slave women in order to operate experimentally on them. Giving them no anesthesia due to their racial "differences" (Blacks purportedly did not feel pain), he addicted them to opiates to regulate their bowel and bladder function. He operated on several of these women 20 or 30 times before obtaining the results he wanted.[99]

The above narration of stories attempts to intentionally center the women subjected to the discovery, in order to hear their voices, although notably silenced in his-story. Sims's assessment of the

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[94] Patricia A. King, *Race, Justice and Research*, *in* BEYOND CONSENT: SEEKING JUSTICE IN RESEARCH 88–110 (Jeffrey P. Kahn, Anna C. Mastroianni, Jeremy Sugarman, eds., 1998) (Legal Scholar and bioethicist Patrica King notes that "given the other aspects of slave life, it is not clear that these women would have ranked this problem high on their list of medical problems that needed attention"); Diane Axelson, *Women as victims of medical experimentation: J. Marion Sims's surgery on slave women, 1845-1850*, *in* SAGE 10–13 (1985).

[95] MCGREGOR, *supra* note 52, at 50.

[96] SIMS, *supra* note 7, at 237.

[97] MCGREGOR, *supra* note 52, at 51.

[98] *See generally* GRAHAM J. BARKER-BENFIELD, THE HORRORS OF THE HALF KNOWN LIFE: MALE ATTITUDES TOWARD WOMEN AND SEXUALTIY IN NINETEENTH CENTURY AMERICA (1976).

[99] BYRD & CLAYTON, *supra* note 21, at 273; *see also* David A. Richardson, *Ethics in Gynecological Surgical Innovation*, 170 AM. J. OBSTETRICS & GYNECOLOGY, 1–6, (1994); Seale Harris, *Woman's Surgeon: The Life Story of J. Marion Sims* 108–09 (New York Macmillan, 1950); MCGREGOR, *supra* note 52, at 50–51; KAPSALIS, *supra* note 86, at 31–45. *Contra* Wall, *supra* note 52, at 341 ("[G]ynecological surgeons know that vaginal surgery rarely requires much postoperative pain medication because the vagina is poorly innervated compared to the external genitalia and most patients undergoing vaginal surgery have very minimal postoperative pain, even after extensive vaginal dissection.").

enslaved women's "unfitness for duty" not only subjected them to four years of horrific experiments, but undoubtedly sparked his quest for the discovery of a cure.[100] It also reveals a marginalized, or often times intentionally overlooked, part of the "setting."[101] There exists an interdependency between the laws of enslavement which sanctioned the "duties," and the medical value derived from "repairing" broken property that is deemed "unfit for duty" resulting in the under-discussed exploitation of enslaved Black women for the sake of scientific advancement.

The telling of the medical story on the development of the specialty of gynecology calls for an integration of both his-story and "her-story" in order to acknowledge that Anarcha, Betsey, Lucy, and the other unnamed enslaved Black women—albeit legally sanctioned as inanimate chattel property—no doubt humanly suffered each stitch and restitch during numerous surgical operations without the benefit of anesthesia and underwent postoperative administration of opium during their four-year period of what began as a "season of philosophical experiment."[102]

A CRF approach allows the story teller and the story listener to tell the medical story with the appropriate context of enslavement and the vestiges thereof, including its particularized impact on Black women,[103] in order to provide an honest assessment of the medical value gained from the development of the medical specialty of gynecology in the United States.

The lens of CRF compels the storyteller to not only speak about "unspeakable" things, such as notions of race and racial construction, gender, and locations of power in the health care system—it also encourages the story listener to hear the silence of

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[100] Durrenda Ojanuga, *The Medical Ethics of the "Father of Gynaecology." Dr. J. Marion Sims,* 19 J. MED. ETHICS 28–31 (1993) (discussing Sims' use of female slaves as research subjects).

[101] Wendy Brinker, *J. Marion Sims: One Among Many Monumental Mistakes: A Biographical Sketch, available at* http://www.nathanielturner.com/jmarionsims.htm. South Carolina Activist and Artist Wendy Brinker put it this way:

> The success of J. Marion Sims as "the father of gynecology" in the United States rested solely on the personal sacrifices of the enslaved African women he experimented on from 1845 to 1849. Had they not been his property, giving him carte blanche to cut them open and sew them back up as he saw fit, he could have never devised the surgical technique that brought him international recognition.

Id.; *see also* SCHWARTZ, *supra* note 13, at 4 (noting that "slavery helped to further the medicalization of childbirth and the professionalization of medicine").

[102] SIMS, *supra* note 7, at 236. Sims makes this reference after taking about three months to have instruments made in preparation of the patients to enter into his "hospital." *Id.*

[103] *See generally* Bridgewater, *Ain't I A Slave, supra* note 11, at 120–21.

issues raised but not adequately addressed. [104] It is the inclination "not to discuss" such a vital part of medical history that this piece argues for implementing a notion of CRF Bioethics that begins to address medical education's pursuit of cultural competency.

A CRF lens will enhance one's ability to critically examine issues such as medical ethics and cultural awareness when analyzing Sims's postoperative use of opium on Anarcha, Betsey, Lucy, and the other unnamed enslaved Black women. In the telling of the medical story on the development of gynecology in the United States, C. Lee Buxton comments on Sims:

> Sims' own confidence, dedication, and persistence were not the only elements underlying his success, of course, and of particular importance was the continued presence of patients who were willing to be operated on so many times. Whether it was because they were slaves, or whether their state was so miserable that they were willing to undergo any degree of pain and inconvenience, or whether it was simply that they were regularly given laudenum postoperatively to tie up their bowels for as long as three or four weeks, and thus became addicted, is a matter of conjecture; but it is virtually certain that Sims would not have succeeded had they not been available.[105]

Sims's success as a surgeon, physician, and inventor is memorialized in history—an accepted medical history.[106] A CRF perspective in the telling of the same story suggests an alternate reality by acknowledging the *narrative behind the narrative.* Particularly, if the reality of the patient is traditionally viewed as Susan Wolf describes it, the "genderless generic patient"[107] then an alternate reality should construct a different patient. The *narrative*

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[104] Montoya, *supra* note 31, at 1317–18 (setting forth issues of Critical Race Theory or CRF to be considered when addressing, "[t]he role that science has played and continues to play in constructing racial identities, and the concepts we understand as "race" or "racialized ethnicities"); *see also* Alexandria C. Lynch, Letter to Editor, *Anarcha's Story*, *available at* http://nathanielturner.com/anarchas_story.htm (stating that "[v]ery recently [she] was particularly affected by [the inequality of not being exposed to the history of the discovery and or circumstances related to the construction of a tool or drug] as she listened to a lecture on the female exam. [She] felt like a large part of history was overlooked when the lecturer commented that she would not discuss the controversial history of the speculum except to say that Dr. [James Madison] Sims created a very useful tool that allows physicians to examine the walls of the vagina and the uterus").

[105] SIMS, *supra* note 7, at ix.

[106] *Id.* at v.

[107] Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J.L. & MED. 395, 402, 405 (1994) [hereinafter Wolf, *Shifting Paradigms*].

behind the narrative acknowledges the historically misappropriated characters of enslaved Black women (raced and gendered) as "patients" subjected to years of medical experimentation, thereby rendering support for Byrd and Clayton's call to reassess the relationship between race, gender, class, medicine, and health care in the United States.[108] Sims purposefully avoided discussing the race of his initial subjects of experimentation in his writings after moving from the South to the North, as well as in the original illustrations accompanying his articles, wherein he substituted white female patients for the enslaved ones who actually endured his first experiments.[109] The practice of a "southern medicine" during the late antebellum era, which explained Black inferiority by pointing to physiological differences in the races, served as a veil for the continuation of the institution of slavery and southern nationalism.[110] It appears that Sims and other surgeons of "great nerve"[111] were willing to pierce the veil when it came to the bodies of enslaved Black women.[112] It should be noted that there is a direct relationship between the story and "the listener's world view."[113] For instance, one of the most significant concerns about critically examining Sims's experiments upon enslaved women is Sims's claim that he "agree[ed] to perform no operation without full consent of the patients"[114] when the laws of enslavement usurped the women's personhood and bestowed consent to their owners.[115]

A CRF lens can provide the story listener with a *narrative behind the narrative* that challenges their world view based upon the exposure to alternate social realities, which are particularly relevant to the burgeoning field of Bioethics.

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[108] BYRD & CLAYTON, *supra* note 21, at 275.

[109] *See* SCHWARTZ, *supra* note 13, at 254; MCGREGOR, *supra* note 53, at 106. For a visual depiction of Sims and Margaret Brennan, illustrating the steps of vesico-vaginal fistula surgery and the Sims's Position, see DR. HENRY SAVAGE, THE SURGERY, SURGICAL PATHOLOGY AND ANATOMY OF THE FEMALE PELVIC ORGANS 117, Plate 24 (William Wood 3d ed. 1880) (from the Special Collections, Southern Illinois University School of Medicine).

[110] *See* SCHWARTZ, *supra* note 13, at 252 ("Only the boldest of doctors performed surgery, which was regarded as a separate medical specialty in the antebellum era even though some general practitioners engaged in it."). *Id.* at 230.

[111] *Id.* at 230 (quoting J. Marion Sims).

[112] *Id.* at 228 ("Because most women—indeed most females—experienced pregnancy and childbirth, obstetric and gynecological cases seemed close to nature and less influenced by race than other factors."). *Id.* at 253.

[113] *See* Jon Robins, *Once Upon a Time . . . Is Storytelling the Missing Ingredient in Legal Education?*, LAW GAZETTE, Aug. 15, 2007, http://www.lawgazette.co.uk/features/once-upon-a-time (quoting Robert McPeake in an interview for the featured article on the *Storytelling Conference*).

[114] Wall, *supra* note 52.

[115] *Id.*

II. FROM BIOETHICS TO CRF BIOETHICS

A notion of medical ethics for people historically deemed as chattel property[116] must begin with acknowledging past complicity between the laws of enslavement and medical advancement. The application of Bioethics to Black people generally, and Black women specifically, is wholly inadequate to address the particular and unique narrative on the development of gynecology in the United States.[117] CRF Bioethics serves as an alternate reality which promotes a non principled-based paradigm,[118] focusing on perspective in order to serve as a basis for Bioethical decision-making.

A. Bioethics

Bioethics is traditionally defined as a branch of ethics concerned with issues surrounding health care and the biological sciences.[119] The historical and modern literature on "Bioethics" makes interchangeable use of the term "Biomedical ethics." Bioethics is interdisciplinary[120] and still undergoing refinement.[121] However,

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[116] *See generally* JAMES MELLON, BULLWHIP DAYS: THE SLAVES REMEMBER AN ORAL HISTORY (1988) (providing interviews of former enslaved Africans in order to capture the "feelings that arose from the condition of being a statutory slave, of being owned physically, by one's fellow man as a piece of property").

[117] Randall, *supra* note 14, at 231. Randall points out that:

> Eurocentric bioethics focuses on the individual, ignoring the interests of others who are intimately affected, such as family and . . . community . . . . Second, Eurocentric Bioethics embraces Kantian ethics, which are antithetical to Afrocentric bioethics . . . . Third, Eurocentric bioethics tend to view the patient or research subject generically, without attention to race, gender, or insurance status.

Id. at 230.

[118] Wolf, *Shifting Paradigms*, *supra* note 108, at 399. (arguing for a paradigm shift in bioethics which moves away from "something principle- or rule-driven to something more inductivist and empirical"). This paper advocates for starting a conversation that falls outside the traditional four based principled approach—autonomy, beneficence, nonmaleficence, and justice—in order to acknowledge the historical patient (Black female enslaved women) who impacted the development of gynecology.

[119] *See* ENCYCLOPEDIA OF BIOETHICS (W. T. Reich ed., 1978); H. TRISTAM ENGELHARDT, JR., THE FOUNDATION OF BIOETHICS 7 (1986); R. MACKLIN, MORTAL CHOICES: BIOETHICS IN TODAY'S WORLD (1987); DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING 3 (1991); Susan M. Wolf, *Introduction: Gender and Feminism in Bioethics*, *in* FEMINISM AND BIOETHICS: BEYOND REPRODUCTION 7 (Susan M. Wolf ed., 1996) [hereinafter Wolf, *Gender and Feminism*].

[120] Tom L. Beauchamp, *Does Ethical Theory Have a Future in Bioethics*, 32 J.L. MED. & ETHICS 209, 209 (2004) (noting that "bioethics continues on its current course toward a more interdisciplinary and practical field.").

[121] JANET L. DOLGIN & LOIS L. SHEPHERD, BIOETHICS AND THE LAW 5 (2005) (noting that

the seminal work of Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*,[122] is noted for introducing the "'four-principle' approach"[123]—beneficence,[124] nonmaleficence,[125] autonomy,[126] and justice[127]—to Bioethics. The combined nature of the four asserted principles has resulted in an "ethical framework" which the profession has historically accepted as providing general guidance for decision-making.[128]

K. Danner Clouser and Bernard Gert contend that two principles[129]—confidentiality[130] and truth-telling,[131] (honesty, integrity)—should be added to Beauchamp and Childress's

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"[s]ome of the central concepts that inform contemporary bioethics can be derived from that Oath and the Hippocratic corpus (most of which probably was not actually written by Hippocrates).").

[122] *See generally* THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH (1979), *available at* http://ohsr.od.nih.gov/guidelines/belmont.html (prepared by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Ethics).

[123] MARSHA GARRISON & CARL E. SCHNEIDER, THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION 14 (2003) (citing Edmund D. Pellegrino, *The Metamorphosis of Medical Ethics: A 30-Year Retrospective*, 269 JAMA 1158, 1160 (1993)). *Contra* George P. Smith, *Biomedicine and Bioethics: De Lege Lata, De Lege Ferenda*, 9 J. CONTEMP. HEALTH L. & POL'Y 233, 242 (1993) (citing Leroy Walters, *Bioethics as a Field of Ethics*, *in* CONTEMPORARY ISSUES IN BIOETHICS 49, 50–51 (Tom L. Beauchamp & Leroy Walters eds., 1978) (noting that "[t]here are three principle duties, rights, and values within the field of bioethics: autonomy or self-determination, beneficence, and justice")).

[124] Smith, *supra* note 124, at 244 (suggesting that "[t]he prevention of harm and the production of good are the two distinct but related foci of the principle of beneficence; with medical ethics emphasizing the first under the normative command: 'Do no harm.' Accordingly, for the health care professional, in context, this principle means that he or she must take care in his or her actions not to compound an ill patient's condition by causing or complicating further illness").

[125] PATRICIA A. KING, JUDITH AREEN & LAWRENCE O. GOSTIN, LAW, MEDICINE AND ETHICS 45 (3d ed. 2006) (citing TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 12 (5th ed. 2001) (defining "Nonmaleficence" as "a norm of avoiding the causation of harm")).

[126] Smith, *supra* note 124, at 242 (suggesting that "Autonomy, or self-determination, finds its essence and current expression in the rich and evolving tradition of human rights which in turn has had a significant impact on Western social and political thought over the last four centuries").

[127] KING ET AL., *supra* note 126, at 45 (defining "Justice" as a group of norms for distributing benefits, risks, and costs fairly).

[128] Doug Morrison, *A Holistic Approach to Clinical and Research Decision-Making: Lessons From the UK Organ-Retention Scandals*, 13 MED. L. REV. 45, 79 (2005).

[129] K. Danner Clouser & Bernard Gert, *A Critique of Principlism*, 15 J. MED. & PHIL. 219, 228–29 (1990).

[130] BARRY R. FURROW ET AL., BIOETHICS: HEALTH CARE LAW AND ETHICS 5 (1st ed. 1991) (defining Confidentiality as "[t]he principle that when information is divulged by one person to another with the implicit [or explicit] promise that it will not be revealed to any other person that implicit promise should be respected") (citing Clouser & Gert, *supra* note 130).

[131] *Id.* (defining Truth Telling as "[t]he principle that one ought to [accurately and fully] disclose all pertinent information about a person to that person").

framework.[132] The confidentiality principle is rooted in the Hippocratic Oath,[133] while truth-telling gained recognition during the late twentieth century.[134] It is noted that the current debate on truth-telling is central to the evolving nature of biomedical ethics in a culturally pluralist society.[135] Surbone notes that "[b]ioethics . . . originated in the United States and has consequently reflected Anglo-American values, including emphasis on self-governance. In healthcare, patient autonomy became the leading principle of Anglo-American Bioethics, and truth-telling was considered a necessary requirement for patient's self-determination."[136] For purposes of this article, I contend that an alternate reality exists regarding the Bioethics principle of truth-telling from the point of delivery of information as it relates to the specific area of human experimentation on Black women, both past and present.[137]

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[132] *Id.* ("There is also one 'meta-principle' which is often invoked by those engaged in bioethics discussion, the principle of Professional Responsibility.").

[133] *Id.* at 30; *see also* WARD ETHICS: DILEMMAS FOR MEDICAL STUDENTS AND DOCTORS IN TRAINING 85 (Thomasine K. Kushner & David C Thomasma eds., 2001) (noting that the Confidentiality principle can be traced back to the Hippocratic Oath).

[134] *See* WARD ETHICS, *supra* note 134, at 85 (discussing Truth Telling in connection with hypothetical cases involving daily ethical dilemmas experienced from a medical student's perspective and commentary as to how to address them).

[135] *See generally* Kerry Bowman, *What are the Limits of Bioethics in a Culturally Pluralistic Society?*, 32 J.L. MED. & ETHICS 664, 667–68 (2004); Leslie J. Blackhall et. al., *Bioethics in a Different Tongue: The Case of Truth- Telling*, 78 J. URB. HEALTH 59, 60–61 (2001) (discussing an ethnographic study of seniors from four different ethnic groups and their attitudes towards being told the truth about diagnosis and prognosis of a serious illness). For some additional resources on truth-telling in oncology, see Mary R. Anderlik et al., *Revisiting the Truth-Telling Debate: A Study of Disclosure Practices at a Major Cancer Center*, 11 J. CLINICAL ETHICS 251, 252 (2000); Mustafa Ozdogan et al., *"Do Not Tell": What Factors Affect Relative's Attitudes to Honest Disclosure of Diagnosis to Cancer Patients?*, 12 SUPPORT. CARE CANCER, 497, 497, 502 (2004); Antonella Surbone, *Cultural Competence: Why?*, 15 ANNALS OF ONCOLOGY 697, 697–98 (2004), *available at* http://annonc.oxfordjournals.org/cgi/reprint/15/5/697?akznck [hereinafter Surbone, *Cultural Competence*]; Antonella Surbone, *Telling the Truth to Patients with Cancer: What is the Truth?*, 7 LANCET ONCOLOGY 944, 944 (2006); Antonella Surbone, Moderator, Truth Telling and Ethical Issues: An Overview, Address Before the UICC World Cancer Congress 2006 (July 10, 2006) (transcript available at http://2006.confex.com/uicc/uicc/techprogram/P10511.htm) [hereinafter Surbone, Truth Telling] (noting that "[t]he debate surrounding truth-telling has now finally moved worldwide from whether or not to tell the truth to how and when best to share information with [cancer] patients").

[136] Antonella Surbone, Is Truth Telling Still A Taboo in Some Cultures?, Presentation Before MASCC/ISOO 17th International Symposium (June 2005) (presentation summary available at http://www.mascc.org/media/17th_Symposium_Proceedings/contents/summary/003.pdf).

[137] *See generally* Washington, *supra* note 12, at 126.

1. Paradigms and Point of View[138]

The Bioethics paradigm shift,[139] which moves beyond what has become known as "principlism"[140] and its limited adherence to mid-level ethical principles, indicates a response to the reality of the non-generic patient.[141] A manifestation of this response can be expressed through the narrative element of "point-of-view,"[142] which tells the story from the perspective of the one uniquely impacted. In order to acknowledge the Bioethical shifting of paradigms, a number of theories exist to give "being-ness" to the humans subject to ethical decision-making. Furrow's list of nine alternative approaches to the formally principled approach to Bioethics include: Narrative Bioethics[143] (hearing the stories of the participant will enable the listener/physician to realize the proper ending through the power of literature); Virtue Bioethics[144] (Aristotelian Virtue Ethics advocates what a virtuous person would do under any particular circumstances); Ethics of Caring[145] (see the importance of relationships among human beings and weigh the affect of how to resolve the Bioethical dilemma); Religious Bioethics[146] (applying religious reasoning to Bioethical dilemmas to replace the secular mantra of autonomy, beneficence, and justice); Casuistry[147] (practical, case based reasoning similar to the common law system);

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[138] *See* Fajans & Falk, *supra* note 63, at 37 (noting that "[p]oint of view concerns through whose eyes the reader views the action").

[139] *See* Edmund D. Pellegrino, *The Metamorphosis of Medical Ethics: A 30-year Retrospective*, 269 JAMA 1158, 1158 (1993) (noting the shift from principlism to more contemporary bioethical approaches).

[140] *See* Wolf, *Shifting Paradigms*, *supra* note 108, at 400 (according to Wolf "Beauchamp and Childress [have been] wrongly accused of promulgating principlism. Their ethical approach is more complex . . . [y]et it is fair to say that in a great many quarters the [Principles] book has been taken to advance a principlist approach").

[141] *Id.* at 397 (noting that "[i]n bioethics, a plethora of alternative methods has recently been put forth, a new empiricism has challenged the content of previously accepted principles, and burgeoning feminist and race-attentive work has rendered suspect any bioethical approach geared to the generic "patient").

[142] Randall, *supra* note 14, at 192 (discussing narrative through the lens of the African American experience).

[143] Patricia A. Martin, *Bioethics and the Whole: Pluralism, Consensus, and the Transmutation of Bioethical Methods into Gold*, 27 J. L. MED. & ETHICS 316, 316 (1999) (defining Narrative Bioethics).

[144] CONTEMPORARY ISSUES IN BIOETHICS 18 (Tom L. Beauchamp et al. eds., 7th ed. 2008) (defining and discussing Virtue Bioethics).

[145] *Id.* at 19 (discussing and defining Ethics of Caring).

[146] LAURA JANE BISHOP & MARY CARRINGTON COUTTS, 1 KENNEDY INST. ETHICS, RELIGIOUS PERSPECTIVES ON BIOETHICS (1994), *available at* http://bioethics.georgetown.edu/publications/scopenotes/sn25.pdf (explaining Religious Bioethics and providing scholarly works on the subject).

[147] Martin, *supra* note 144, at 316 (defining Casuistry).

Pragmatism[148] (practical application for Bioethical decision making based upon respect for the fact that different people will apply different forms of ethical analysis); Law and Economics[149] (advocates for a Libertarian position applying traditional economic models to resolve Bioethical dilemmas that support an individual freely and fairly entering into private agreements concerning medical treatment); Critical Race Theory[150] (attention to different racial and cultural backgrounds in light of race relations and cultural domination); and Feminist Bioethics[151] (feminist perspective, albeit the development of various strands, such as Liberal Feminism, Cultural Feminism, Dominance or Radical Feminism, Postmodern Feminism, and Critical Legal Feminism focus on elements of women's personal and socially "situated" experiences as a viable approach to Bioethical decision making).[152] The acknowledgement of advances beyond the four-principled approach is indicative of Wolf's paradigm shift in Bioethics.[153] Still, there is a need to address the unique and particularized location of Black women and Bioethics historically and presently particularly as to experimentation and reproductive issues.[154] This article begins to explore how a notion of CRF Bioethics is necessary to fill the gap in telling her story based upon her lived experiences in the doctor-patient relationship by utilizing strands that exists in African American Bioethics,[155] Narrative Bioethics, Critical Race Theory, and Feminist Bioethics.

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[148] *Id.* at 317 (defining Pragmatism).

[149] *See* CONTEMPORARY ISSUES IN BIOETHICS, *supra* note 145, at 22 (defining respect for autonomy as a principle rooted in "individual freedom and choice.").

[150] *See* Randall, *supra* note 14, at 192–93 (discussing Critical Race Theory through an African American perspective).

[151] CHRISTINE OVERALL, ETHICS AND HUMAN REPRODUCTION: A FEMINIST ANALYSIS 2 (1987) (providing "a critique of antifeminist and nonfeminist approaches to reproductive ethics"); Mary C. Rawlinson, *The Concept of a Feminist Bioethics*, 26 J. MED. & PHIL. 405, 413 (2001) (noting that "[F]eminist bioethics, in its variety, is defined by this project of beginning from women's experiences and bodies in formulating the problems, principles, and concepts of ethics.").

[152] Wolf, *Shifting Paradigms*, *supra* note 108, at 400 (noting the "proliferation of alternatives to principlism").

[153] *See generally id.*

[154] *See generally* ROBERTS, *supra* note 20.

[155] AFRICAN AMERICAN BIOETHICS: CULTURE, RACE, AND IDENTITY, at xv–xx (Lawrence J. Prograis Jr. & Edmund D. Pellegrino eds., 2007) (suggesting that the distinct African American experience in the United States through the lens of religion, health, and work lays the foundation for addressing difference in the broader context of cultural and racial identity).

2. "Human" Experimentation and "The End" Result

The accepted narrative on the subject of human experimentation and Bioethics generally starts with Nuremberg.[156] The Nuremberg moral from the story is incomplete without an acknowledgement of the fact that:

> [t]he Nazi experiments were not simply a perversion of medical science; they were also an extension of that science . . . the arrogance of modern science led some physicians in the Nineteenth Century intentionally to infect healthy, but obviously uninformed and powerless, men, women, and even children with venereal diseases and to administer noxious and sometimes permanently harmful substances to them.[157]

The extension of science and government complicity in race based human experimentation most notably lies in the *Tuskegee Syphilis Experiment*.[158] A fiction based account of this real human atrocity is memorialized in David Feldshuh's play *Miss Evers' Boys*, eventually presented in the 1997 Home Box Office cable television movie.[159] The characters in fiction, as well as the ones in life, tell the story of how "moral silences"[160] contextualize the historical and present day role of the medical professional clothed in ambition and medical

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[156] Alexander M. Capron, *Experimentation with Human Beings: Light or Only Shadows?*, 6 YALE J. HEALTH POL'Y L. & ETHICS 431, 436 (2006) (reflecting on the lessons of Nuremberg and "[l]ooking to the eponymous code that for most bioethicists is 'Nuremberg,' the lessons appear to be that investigators must not use human beings for research without their free and informed consent, that those human subjects must remain free to withdraw from research despite that consent, and that the risks must be minimal and always proportionate to scientific ends that are themselves reasonably attainable" (footnote omitted)). *See generally* JAY KATZ ET AL., EXPERIMENTATION WITH HUMAN BEINGS: THE AUTHORITY OF THE INVESTIGATOR, SUBJECT, PROFESSIONS, AND STATE IN THE HUMAN EXPERIMENTATION PROCESS (1972) (seminal casebook which addresses the "medical experiments" conducted in concentration camps).

[157] Capron, *supra* note 157, at 436–37 (noting the propensity to treat hospital patients as "material" for medical education); *see also* SUSAN E. LEDERER, SUBJECTED TO SCIENCE: HUMAN EXPERIMENTATION IN AMERICA BEFORE THE SECOND WORLD WAR 9 (1995).

[158] *See generally* JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT (1993); FRED GRAY, THE TUSKEGEE SYPHILIS STUDY: AN INSIDERS ACCOUNT OF THE SHOCKING MEDICAL EXPERIMENT CONDUCT BY GOVERNMENT DOCTORS AGAINST AMERICAN MEN (1998); TUSKEGEE'S TRUTHS: RETHINKING THE TUSKEGEE SYPHILIS STUDY (2000).

[159] DAVID FELDSHUH, MISS EVERS' BOYS (1995); GRAY, *supra* note 159, at 16, 109 (noting that "[m]any of the men involved in the study were deeply offended by [the movie version], which they felt misrepresented them and the facts of the study").

[160] Capron, *supra* note 157, at 435–36 (defines a notion of "*vocabulary of relationships* . . . as language not solely of duties but of hopes and fears, of uncertainties and magical thinking" that can "fill the gaps, the moral silences, at the heart of human experimentation").

advancement—the end.[161] However, viewed against the background setting of a racialized science that allowed the pursuit of scientific knowledge to "do harm" and preempt the informed consent of the unsuspecting Black male research patients.[162]

In this article, my particular focus is to shed light on the story of enslaved Black women, Bioethics, and human experimentation of the past which has laid the foundation for the present day medical specialty of gynecology.[163] The Black woman's "womb has served and continues to serve as a discovery zone"[164] for reproductive and scientific knowledge.

3. CRF Bioethics

CRF Bioethics would begin to address the need for a non-principled paradigm that acknowledges how the laws of enslavement and the means to medical advancement support the notion of *historical* truth-telling in order to inform and cultivate culturally competent physicians,[165] particularly in the area of gynecology.

In terms of an alternate Bioethics, CRF Bioethics would inevitably pull from various strands of Bioethics in order to tell the unique and particular narrative of Black women and Bioethics. From Prograis and Pellegrino's African American Bioethics, there is recognition that:

> African Americans, and Africans as well, . . . have moral beliefs and values that diverged from the Western and Anglo-American values that dominate[s] academic bioethics. These beliefs [have] their roots in the uniqueness of the

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[161] Ruth Faden, *Response: Reflection on Jay Katz's Legacy*, 6 YALE J. HEALTH POL'Y L. & ETHICS 451, 452 (2006) (arguing that scholars of biomedical ethics have resorted to shifting language: "'human experiments' have become 'clinical trials' and 'research studies,' and . . . human beings . . . have become 'research participants,' rather than 'human subjects' . . . [in order] to soften the moral edginess of human experimentation, to make it more acceptable, more routine").

[162] *See generally* JONES, *supra* note 159; GRAY, *supra* note 159.

[163] SCHWARTZ, *supra* note 13, at 256 ("[Antebellum southern surgeons] wanted to advance medicine and looked to enslaved [women] as a means of developing and perfecting a range of gynecological treatments to be used on all women.").

[164] Washington, *supra* note 12, at 129; *see* BYRD & CLAYTON, *supra* note 21, at 272–75; WASHINGTON, MEDICAL APARTHEID, *supra* note 21, at 189–215.

[165] KATHLEEN FULLER, ERADICATING ESSENTIALISM FROM CULTURAL COMPETENCY EDUCATION 198 (2002) (noting that "[p]hysicians cannot assume that they will treat only those with whom they share ancestry and culture. They must assume that the patient population will be diverse. Therefore, it is incumbent on medical educators to train physicians who are capable of interacting appropriately and effectively with a broad array of individuals from a broad array of populations and cultures").

> African American experience: in some of the traditions of African culture, and *especially in the experience of slavery,* and the residual discrimination that is still an actuality in American life.[166]

CRF Bioethics will specifically address the oftentimes under-discussed "different" experience of Black enslaved women due to the demand for sexual exploitation for purposes of breeding, particularly after 1808,[167] as well as human experimentation for reproductive knowledge.

Narrative Bioethics offers a reference for acknowledging the "lived experiences"[168] of women. CRF Bioethics would ensure that the "women" include the voices of women of color and their particular lived experiences, which almost invariably include the experiences of past women of color's lives—those stories told and untold through the spoken word, but nevertheless passed down from one generation to the next.[169] Critical Race Theory,[170] with its race-attentive[171] analysis, coupled with Feminist Bioethics'[172] gender and feminist attentive analysis, provides a foundational basis in support of a CRF Bioethics.

Susan Wolf's influential work, *Feminism and Bioethics: Beyond Reproduction*, suggests that Bioethics concerns itself preeminently with the protection of vulnerable patients and research subjects.[173] It is the relationship between medical and scientific fact and social meaning, and ethics that should guide physicians and scientists.[174] Bioethics in isolation of critical race feminism, as defined by Adrienne Wing, is rooted in critical legal studies and looking at

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[166] AFRICAN AMERICAN BIOETHICS, *supra* note 156, at xii (emphasis added).

[167] SCHWARTZ, *supra* note 13, at 1 ("The vested interests of slaveholders in enslaved women's childbearing encouraged owners to take measures, some coercive, to ensure that they had the opportunity to conceive and bring a baby to term.").

[168] Rebecca Dresser, *What Bioethics Can Learn from the Women's Health Movement, in* FEMINISM AND BIOETHICS, *supra* note 120, at 154.

[169] Randall, *supra* note 14, at 191–95 (noting the lack of trust of the health care system).

[170] FURROW ET AL., *supra* note 131, at 12 ("We could not do a serious evaluation of research involving human subjects during this century without taking notice of how racism manifested itself in abuses in medical laboratories across the world."). *See generally* THE LAW UNBOUND!: A RICHARD DELGADO READER 91 (Adrien Katherine Wing & Jean Stefancic eds., 2007).

[171] Wolf, *Gender and Feminism*, *supra* note 120, at 6; Wolf, *Shifting Paradigms*, *supra* note 108, at 406–07.

[172] Wolf, *Gender and Feminism*, *supra* note 120, at 21.

[173] *See generally id.* at 6.

[174] *See generally* Ana E. Nunez, *Transforming Cultural Competence into Cross-Cultural Efficacy in Women's Health Education*, 75 ACAD. MED., 1071 (2000) (arguing that "[c]linicians must deal not only with such obvious cultural differences of their patients as language, dress, and diet, but also with more subtle cultural influences, such as the patient's perceptions of health, illness, and appropriate approaches to treatment").

differential power relationships.[175] The most evident power differential in a medical setting is from doctor to patient, in the sense of power and control. Dorothy Roberts argues that "the political dimension of the doctor-patient relationship is more apparent where the patient is a woman of color. Doctors treat these women differently than they treat their white female patients because of racism."[176] It is precisely at the axis of acknowledging the difference—difference in the Black women's experience as to slavery in the United States, difference in her narrative as a woman of color, and difference as to her treatment as "patient"/subject of experimentation—that calls for an alternate approach to Bioethics.

A notion of CRF Bioethics, which focuses on the realities of women of color, with aspects of alternate approaches such as African American Bioethics, Narrative Bioethics, Critical Race Theory, and Feminist Bioethics would pay particular attention to historical appropriations of reproductive knowledge, from the bodies of the women of color and their particular experiences interfacing with the healthcare system of the past and of the present.

III. MEDICAL SCHOOLS' PURSUIT OF "CULTURAL COMPETENCY"

This attempt to link scholarship on race and gendered race with pedagogy on language and culture provides us with an opening to find new applications for CRF.[177]

No medical school can train students in empathy. But, we have a duty to equip them with the ability to see, to articulate, to grasp, and to comprehend the position of the patient.[178]

The existing gap in reproductive health care between white

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[175] *See generally* CRITICAL RACE FEMINISM: A READER 1–5 (Adrienne Katherine Wing ed., 2d ed. 2003).

[176] Dorothy E. Roberts, *Reconstructing the Patient: Starting with Women of Color*, *in* FEMINISM AND BIOETHICS, *supra* note 120, at 117. Roberts does not argue the position that women of color have a common or unique moral viewpoint, however she clearly points out:

> [H]ow the perspective of poor women of color—their particular relationship to the institution of medicine—can uncover the way in which the practice of medicine, particularly the doctor-patient relationship, perpetuates hierarchies of power, can highlight women's forms of resistance to medical control, and can propose a vision for transforming medical ethics and the health care system.

Id.

[177] Montoya, *supra* note 31, at 1319 (noting the importance of applying legal theory to the practice of medicine in order to address "the issues that have engaged [the] scholarly interests as critical race feminists" and meet the societal need for more culturally competent doctors).

[178] Dinitia Smith, *Diagnosis Goes Low Tech*, N.Y. TIMES, Oct. 11, 2003, at B9, *available at* http://query.nytimes.com/gst/fullpage.html?res=9D04E7DC153FF932A25753C1A9659C8B63&sec=health&spon=&pagewanted=all.

women and women of color in general,[179] and Black women[180] specifically, can begin to be addressed by acknowledging the *narrative behind the narrative* of three enslaved Black women in tandem with the existing medical narrative of the development of gynecology in the United States as a means of achieving "cultural competency" in medical schools. The nexus between law and medicine is age-old.[181]

Dr. Troy Duster argues that "[w]hile every period understandably claims to transcend . . . categories, medicine, law, and science are profoundly and demonstrably influenced by the embedded folk notions of race and ethnicity."[182] The notion of historical truth-telling would require a recognition of social hierarchy and accepted narratives of medical history.[183] It is the unearthing of so-called "embedded" notions of race, gendered race, and ethnicity that a CRF Bioethics approach serves as a tool to help medical schools attain cultural competency goals.

A. Cultural Competency Goals

Currently, there is extensive dialogue in medical schools and institutions funded by the federal government on how to achieve

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[179] Angela Hooton, *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL'Y & L. 59, 60 (2005). *See generally* Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 76 (2003) (Ikemoto argues that "[a] close look at the health care industry's institutional practices reveals an English-only, ethnocentric, racist culture that does interfere with patient care.").

[180] *See generally* Charlotte Rutherford, *Reproductive Freedoms and African-American Women*, 4 YALE J.L. & FEMINISM 255 (1992) (discussing the African-American want and need of "reproductive freedoms" which range from the ability to terminate pregnancies to the ability to deliver babies under healthy and safe circumstances).

[181] Troy Duster, *Lessons from History: Why Race and Ethnicity Have Played a Major Role in Biomedical Research,* 34 J.L. MED. & ETHICS 487, 487 (2006) (noting that "[p]erhaps it has always been so, but certainly in the post-Enlightenment era there are inevitable linkages between the fields of law, medicine, and science. Each of these realms of activity is embedded in the social milieu of the era, with practitioners emerging from families, communities, regions, and nations bearing deep unexamined assumptions about what is natural and normal. Equally important, these fields' theoretical accounts of natural behavior will tend to dovetail and fit each other's—most especially as they pertain to the grand social issues of the period").

[182] Symposium, *The Responsible Use of Racial and Ethnic Categories in Biomedical Research: Where Do We Go From Here?*, 34 J.L. MED. & ETHICS 479 (2006).

[183] *See* MCGREGOR, *supra* 52, at 220 (McGregor correctly states that "[t]elling the story straight includes examining all the players and acknowledging the misuse and exploitation as well as triumphs. All too often, medical history as part of the larger society has resisted including the examination of the relevance of social hierarchy and the biases that keep people categorized: how they are at least as much at work in the medical world as they are elsewhere.").

cultural competency in order to improve quality and eliminate racial and ethnic disparities in healthcare.[184] The goal of cultural competency is to provide health care that meets the patient's "social, cultural and linguistic needs."[185] Brach argues that "[s]ome advocate for cultural competency as a matter of social justice. According to this perspective, the high value we as a society place on informed consent, choice of providers, and equity creates an entitlement to cultural competency regardless of its impact on outcomes."[186] The current synergy between the legal and medical academies' movement toward a narrative approach to pedagogy is in need of a vehicle such as CRF Bioethics to adequately address the traditional notion of a genderless, race-less, generic, English-only speaking "patient."

Surbone correctly points out:

> Effective cultural competence is based on increasing physicians' knowledge of the concept of culture as well as of the key notions related to culture (such as stereotyping, racism, classism, sexism); on nurturing appreciation for difference in health-care values; and finally on fostering the attitudes of humility, empathy, curiosity, respect, sensitivity and awareness.[187]

The culturally competent training of physicians should begin with *historical* truth-telling which present an accurate narrative of medical advancements, science, and technology.[188]

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[184] *See* Montoya, *supra* note 31, at 1314–15; Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, & Elyse R. Park, *Cultural Competence And Health Care Disparities: Key Perspectives And Trends*, 24 HEALTH AFF. 499, 503 (2005), *available at* http://content.healthaffairs.org/cgi/reprint/24/2/499.

[185] Joseph R. Betancourt, Alexander R. Green, & J. Emilio Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, COMMONWEALTH FUND (Oct. 2002), *available at* http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2002/Oct/Cultural-Competence-in-Health-Care--Emerging-Frameworks-and-Practical-approaches.aspx#citation.

[186] Cindy Brach & Irene Fraserirector, *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 MED. CARE RES. & REV. 181, 183 (2000), *available at* http://www.vdh.virginia.gov/ohpp/clasact/documents/CLASact/research3/CCC%20model%20to%20reduce%20disparities%20brach.pdf.

[187] Surbone, *Cultural Competence*, *supra* note 136, at 698.

[188] *See* William Vega, *Higher stakes ahead for cultural competence*, 27 GEN. HOSP. PSYCHIATRY 446, 448–50 (2005) (Dr. Vega advocates for comprehensive training and continued research and support to develop and integrate cultural competency into all aspects of clinical care).

B. Truth-Telling (Medical School Curriculum)

Truth-telling is at the core of contemporary biomedical ethics, where it relates to the doctrines of informed consent and cultural competence.[189] Currently, there is a move in medical education to pay particular attention to the preparation of students "to care for patients from diverse social and cultural backgrounds, and to recognize and appropriately address racial, cultural, and gender biases in healthcare delivery."[190]

I argue that the Bioethics principle of truth-telling should be expanded to include *historical* truth-telling that critically examine the intersectionality of race and gender and their impact on medical science and technology is needed. For example, the telling of Anarcha, Betsey, and Lucy's narrative could be utilized in discussions on consent and human experimentation. According to Dr. J. Marion Sims's memoir, the enslaved women "willingly consented"[191] to undergo the experimental surgeries. However, if hearing this statement from a "her-storical" lens, one must question to what extent Anarcha, Betsey, Lucy, or any other enslaved Black woman could have granted Sims "consent,"[192] as they legally did not own their body or the children that they bore.[193]

The construction of race and its related biological science to

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[189] Surbone, Truth Telling, *supra* note 136.

[190] Joseph Betancourt, *Cross-cultural Mediccal Education: Conceptual Approaches and Frameworks for Evaluation*, 78 ACAD. MED. 560 (2003). Betancourt correctly points out:

> It is not only the patient's culture that matters: the providers "culture" is equally important. Historical factors for patient mistrust, provider bias, and their impacts on physicians' decision making have also been documented. Failure to take sociocultural factors into account may lead to stereotyping, and, in worst cases, biased or discriminatory treatment of patients based on race. culture, language proficiency, or social status.

Id.; *see also generally* Jann L. Murray-Garcia & Jorge A. Garcia, *The Institutional Context of Multicultural Education: What is Your Institutional Curriculum?*, 83 ACAD. MED. 646 (2008) (noting that "[f]ew [multicultural training modules] have taken a critical perspective on how an individual trainee must learn, change his or her behavior, and sustain that behavioral change within a specific institutional context").

[191] *See* SIMS, *supra* note 7, at 234.

[192] DIANA SCULLY, MEN WHO CONTROL WOMEN'S HEALTH: THE MISEDUCATION OF OBSTETRICIAN-GYNECOLOGISTS 42 (Teacher College Press 1994) (1980). Scully correctly dispels any notion of "consent" by pointing out that "[s]laves had no rights." *Id.* When surgery was to be performed, the owner, not the slave, gave permission. *Id.* Sims is reported to have purchased one woman, on whom he wanted to operate, when permission wasn't granted by her owner." *Id.*

[193] MORGAN, *supra* note 11, Introduction (Morgan notes that "[s]lavewoners appropriated [enslaved womens'] reproductive lives by claiming children as property, by rewriting centuries-old European laws of descent, and by defining a biologically driven perpetual racial slavery through the real and imaginary reproductive potential of women whose "blackness" was produced by and produced their enslavability.").

support the notion of "other" is evidenced in the telling of the accepted medical narrative regarding the use of anesthesia and medical ethics during the early nineteenth century. The "character" of enslaved Black women, notably Anarcha, Betsey, and Lucy, categorically denied their personhood, yet medically granted the status of "patient" for purposes of human experimentation, only to be marginalized once the narrative was retold for purposes of medical advancement and reproductive technology. In the role of "patient," Anarcha, Betsey, and Lucy were "othered" to the extent that Sims did not provide them with anesthesia prior to the experimental surgeries, but when he moved from the South to the North, he found it necessary to supply white female patients with anesthesia, because they could not withstand the pain.[194] According to Schwartz, Edinburgh obstetrician James Y. Simpson's motivation for performing Sims's innovations on anesthetized pigs was due to "concern for the plight of slaves in the American South or by concern for human subjects generally."[195] Storytellers and story-listeners benefit society as a whole by training culturally competent doctors to see the story that is unwritten and to hear the story that is unspoken. The recognition of a multiplicity of voices,[196] which invariably deconstruct notions of power and acknowledge race and gendered race "stories," presents an opportunity for theory to meet practice—in law schools and in medical schools.

The pursuit of "cultural competency" in medical education, specifically as it relates to telling the medical story of the development of the specialty of gynecology in the United States in tandem with the "narrative behind the narrative" of three enslaved Black women named Anarcha, Betsey, and Lucy, is attainable and it is necessary.

CONCLUSION

> [T]hose who do not fully appreciate the value of the speculum itself have benefited indirectly to an extent they little realize, for the instrument, in the hands of others, has probably advanced the knowledge of diseases of women to a

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[194] *See* MCGREGOR, *supra* note 52, at 51.

[195] SCHWARTZ, *supra* note 13, at 254, 255 (opining that adherence to medical ethical standards could have served as a constraint on surgeons who lived outside the South regarding anesthesia usage and experimentation on patients).

[196] *See* Matsuda, *supra* note 33.

> point which could not have been reached for a hundred years or more without it.[197]

A notion of CRF Bioethics looks at merging African American Bioethics, Narrative Bioethics, Critical Race Theory and Feminist Bioethics, and adopting an ultimate perspective-based Bioethics which will have those considerations that confront past social construction of race, and perhaps actually on its face deal with the historically based and well-founded distrust of the healthcare system by Black people generally and Black women specifically.

It allows us to take a closer look at the laws of enslavement with the societal construction of race and legal notions of chattel property, which made people of African descent things to be owned, transported, used and abused, figuratively as well as literally, resulting in a medical story that generally speaks to the end results—scientific advancement and technology.

CRF Bioethics serves as a viable means to critically examine multiple perspectives which can begin to address the cultural competency goals medical schools are pursuing—to improve the quality and delivery of health care and address racial and ethnic disparities.

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[197] SIMS, *supra* note 7, at 27.